PRINTED: 02/28/2012 Division of Health Care Facilities FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING TN6201 NAME OF PROVIDER OR SUPPLIER 02/21/2012 STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD EAST TENNESSEE HEALTH CARE MADISONVILLE, TN 37364 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY N 000 Initial Comments N DDO N 401 1200-8-6-.04(1) An annual Licensure survey was conducted at East TN Health Care on February 6, 2012. Administration through February 21, 2012. The facility was cited a Type A penalty for failure to follow a systematic Requirement: process of assessing for appropriate use of the restraint and failure to reduce or eliminate side rail restraints for residents (#41, #60, and #18). The administrator shall assure the fallure to reduce or eliminate a side rail restraint provision of appropriate after multiple falls from the bed with full side ralls resources and personnel required to in use for resident (#41), and failure to identify the meet the needs of the residents. risk for side rail entrapment for resident (#18, and #60). The facility's failure placed residents #41, #60, and #18 in an environment that was Corrective Action Plan: detrimental to his/her health, safety, and welfare. 1. As of 3/5/12, the facility is N 401 1200-8-6-.04(1) Administration N 401 providing a safe environment (1) The nursing home shall have a full-time through the comprehensive (working at least 32 hours per week) assessment of each resident administrator licensed in Tennessee, who shall including #41, 60, 18, 55, 94, 57, and not function as the director of nursing. Any 83 to meet the resident's needs and change of administrators shall be reported in maintaining their optimal physical, writing to the department within fifteen (15) days. The administrator shall designate in writing an mental and psychosocial well being. individual to act in his/her absence in order to provide the nursing home with administrative 2. (a) The Administrator with the direction at all times. The administrator shall assure the provision of appropriate fiscal assistance of the Nursing resources and personnel required to meet the Administration Staff has reviewed needs of the residents. the needs of all patients to ensure that safety measures are maintained. New equipment or supplies was ordered and implemented as needed to ensure the resident's optimal This Rule is not met as evidenced by: physical, mental and psychosocial Based on medical record review, facility policy review, review of training seminar information. well being is maintained. review of Guidance for Industry and FDA (Federal Division of Health Care Facilities

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TITLE

PRINTED: 02/28/2012 FORM APPROVED Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WNG 02/21/2012 TN6201 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 465 ISBILL RD EAST TENNESSEE HEALTH CARE MADISONVILLE, TN 37354 -PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRFFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 401 1200-8-6-.04(1) cont... N 401 N 401 Continued From page 1 The Administrative Drug Administration) staff, dated 2006, 3.(a)observation, and interview, the facility failed to be (Administrator, Director of Nursing, administered in a manner to ensure seven and Maintenance Director residents (#41, #60, #18, #55, #94, #57, #83) were provided a safe enviornment of fourty-three Maintenance Asisstant) was residents reviewed. The facility's failure to serviced on 2/7/12, 2/13/12, and/or provide a system to assess for the use of 2/21/12 by the Regional Nurse siderails, to reduce or eliminate full siderails to prevent falls and to reduce the risk of entrapment Consultant and/or Regional Director placed residents #41, #60, and #18 and any of Operations on side rail standards, resident who used full side rails, in an environment which was detrimental to their assessment prior to and ongoing use health, safety and welfare. of restraints/side rails, resident assessments, revision of care plans, The findings included: how to measure side rails and the Interview with the Director of Nursing (DON) on recommended zone measurements February 6, 2012, at 7:50 p.m., confirmed the per FDA Hospital, Bed System facilty became aware of the potential for entrapment with the use of the current full length Assessment Dimensional and siderails and the use siderails as restraints while Guidance to Reduce Entrapment attending a training seminar the past summer dated March 10, 2006, investigation "sometime prior to August 1, 2011." occurrences Interview with the Nursing Home Administrator implementation of interventions to (NHA) and the DON on February 7, 2012, at 9:50 a.m., confirmed the Corporate Office some time reduce the occurrence of incidents, prior to August 1, 2011, had instructed the facility effectiveness monitoring Administration to reduce the full siderails if possible. Continued interview confirmed the interventions, referring residents for DON after return from the training seminar had therapist for by assessment made the Interdiscplinary Team aware and maintenance had started ordering siderails, interventions, job appropriate entrapment proof bars and half siderails to responsibilities, abuse protocol (list replace them as needed.

Interview with the NHA and review of a training

seminar information form on February 17, 2012, at 3:20 p.m., confirmed the NHA had attended

all inclusive: investigation,

reporting, screening of employees,

employee training).

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WNG

TN6201

STREET ADDRESS, CITY, STATE, ZIP CODE

465 ISBILL RD

MADISON/WILE TN 37364

EAST TEN	NNESSEE HEALTH CARE	465 ISBILL RD MADISONVILLE, TN 37354				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE , CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
N 401	Continued From page 2 the same training seminar the DON had previously attended related to siderails as a restraint and as an entrapment risk on Octobe 25, 2011. Continued interview and review of training seminar information form confirmed the training seminar included training and information use of siderails as restraints and the use of certain types of siderails with entrapment risk	the he ation of	N 401 1200-8-604(1) cont 4. (a) The Administrator or Director of Nursing will conduct random			
N 424	1200-8-604(15) Administration (15) Each nursing home shall adopt safety policies for the protection of residents from accident and injury.	N 424	audits weekly through facility walking rounds, review of the 24 hour report, care plans, Nurse Aide Communication Sheets, Evaluation for the Use of Side Rails, and Nurse Event notes to ensure that the			
	This Rule is not met as evidenced by: Based on medical record review, facility policy review, Guidance for Industry and FDA (Food Drug Administration) Staff, observation, and interview, the facility failed to reduce or elimin a siderail restraint after multiple falls from the with full side rails in use, for one resident (#41 two residents reviewed, failed to identify the refor side rail entrapment for two residents (#18 #60) of two residents of twenty-three resident reviewed for siderails, failed to assure safety devices were on and properly operating for two residents (#57, #94) two of two residents of the residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#5 forty-three residents reviewed. The facility's failure placed residents #41, #6 and #18, in an environment which was detrimental to their health, safety and welfare.	and nate bed 1) of isk 8, is vo en 0 5) of	delivery of care is provided to meet the resident's goal. The facility will provide equipment as needed in order to achieve the resident's highest functional status. The Administrator will report findings in the morning Quality Assurance Meeting (Monday-Friday) and review with the Medical Director in the quarterly QA to assist residents in meeting resident's meeting and as needed. (b) The Regional Nurse Consultant will conduct random audits of facility documentation and random patient / staff interviews to ensure facility is maintaining compliance			

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WNG TN6201 02/21/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD EAST TENNESSEE HEALTH CARE MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) N 424 Continued From page 3 N 424 N 401 1200-8-6-.04(1) cont... The findings included: with facility, State and Federal Resident #41 was admitted to the facility on Policies/Regulations. September 23, 2011, and readmitted to the facility on October 24, 2012, with diagnoses (c) The Regional Director of including Alzheimer's Disease, Deep Vein Operations will conduct random Thrombosis, and Hypertension. audits during visits to ensure the Medical record review of the Current Nurse Aide facility is being operated following Communication Worksheet revealed Facility, State, and Federal "...interventions put in place...don't leave in DR Policies/Regulations and maintaining (dining room) unattended when up in W/C (wheelchair)...check alarm during daily routine for the resident's optimal physical, placement...monitor resident while in room and 3/5/12 mental and psychosocial well being. up in chair..." Medical record review of a Fall Risk Assessment dated September 23, 2011, revealed "...moderate risk for falls...equipment issues (types of equipment used)...include side rails..." Medical record review of the Admission Care Plan dated September 23, 2011, revealed "...Frog (falls reduction our goal) program...call light in reach..." Medical record review of the September 2011. Physician Recapitulation Orders revealed "...pressure alarm release applied to bed D/T (due to) decrease of safety awareness check every shift for placement rt (related to) function...Lovenox (anticoagulant) 40 mg (milligrams) subcutaneous every day..." Medical record review of the Physical Therapy Plan of Treatment dated SOC (start of care) dated September 25, 2011, revealed "...risk for falls can be combative ... "

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rails in the up position.

resident was placed back in the bed with the side

Assessment documentation notes reference date

Medical record review of the Resident

The

immediately changed to full anti-

entrapment rails (prior to the exit of

the surveyors) on 2/6/12 by the

Director.

Maintenance

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING TN6201 02/21/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 465 ISBILL RD EAST TENNESSEE HEALTH CARE MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) N 424 N 424 Continued From page 5 measurements for the bed zones September 30, 2011, revealed "...bed rail restraint were obtained by the Maintenance used in bed...climbs out of bed over Director on 2/6/12 using a standard rails...currently...both side rails up..." The Side Rail tape measure. Medical record review of a Nurse's Event Note Assessment and Informed Consent dated October 4, 2011, at 4:30 a.m., revealed "...pt (patient) on his knees at side of bed holding Form (one form) was later completed on to (raised) bed rails...pulled self to standing by the Staffing Coordinator on position...both alarms appeared to be turned 2/6/12 for the use of side rails with a off...abrasion x (times) 3...". Continued review revealed no new interventions and no intervention reduction from full side rails to ½ to remove the siderails. side rails after receiving Telephone interview with LPN #3, on February physician's order for the use of ½ 14, 2012, at 6:45 a.m., confirmed the resident rails by the Staffing Coordinator was found in the floor on October 4, 2011, at 4:30 (after the exit of the surveyors for the a.m., and the side rails were in the up position. evening) that were changed out per Medical record review of the Nurse's the Maintenance Director. The bed Readmission Assessment dated October 24. 2011, revealed the resident required assist with zone measurements were obtained by all activities of daily living, incontinent of bowel the Maintenance Director on 2/6/12. and bladder, combative at times, unable to make A Pre-Restraint Assessment was decisions, and history of falls. completed on 2/21/12 by the Staffing Medical record review of the Fall Risk Coordinator that indicated side rails assessment dated October 24, 2011, revealed "...high risk for falls...equipment issues...include being used as a restraint and assisting side rails..." the resident with position changes. Medical record review of a Physician's Order An Evaluation for the use of Side dated November 16, 2011, revealed "...D/C Rails was completed on 2/23/12 by (discontinue) pressure bed alarm and W/C (wheel chair) alarm..." Medical record review of a physician's order dated November 23, 2011, revealed "...Coumadin (anticoagulant) 5 mg every day at 1600..." Medical record review of a Nurse's Event Note

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDIN	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		TN6201		B. WING _		02/2	1/2012	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, ST	TATE, ZIP CODE			
EAST TEN	NNESSEE HEALTH CARE	Ē	465 ISBILL I MADISONVI		354		20	
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N 424	page	e 6 2011, at 6:00 a.m., reve		N 424	N 424 1200-8-604(15) co	ont		
		beside bed resident had			the Staffing Coordinator	with a		
	climbed over the side railsskin tearabrasion"				reduction of side rails from			
			554.50000		rails to ¼ side rail in com			
	Review of the fall investigation report dated November 23, 2011, completed by the DON				The appropriate and the control of the property of the control of	A SHARLES AND A		
	revealed "climbed or				with a low bed. The bed/s		9. 46.	
		ealed no new intervention	ons		were changed out b	by the		
	and no intervention to	o remove the siderails.			Maintenance Director; measu	ırements		
	Talanhana intonvious	ill I DN #0			were obtained on 2/23/12.	The care		
		vith LPN #2, on Februar , confirmed LPN #2 was			plan was audited by the	entranta peratuan	į.	
-		nt was found on the floor			Administration Staff to ens			
	climbed over the side	rails on November 23,				Seaton and Company of the Seaton State of the		
1	2011, at 6:00 a.m., and	d the alarm did not sou	nd.		the plan of care had been up			
!	interview with Certified	Nurse Aide (CNA) #1	on !		reflect the resident's current	it status		
		3:25 p.m., in the Nurse			on 2/26/12.			
	Station, confirmed CN	IA #1 was on duty and			(c) Resident #18 The side ra	ails that		
		41, on November 23, 2		Į.	were in place during the surv			
		e resident climbed over to the floor, and the bed	the	J	1 -	- 33		
	alarm did not sound.	the noor, and the bod		1	immediately changed to fu	6		
					entrapment rails on 2/6/12	by the		
100		of the Nurse's Event No		J	Maintenance Director after re	eceiving		
		 revealed the residen de chair unattended ar 	DF3	1	a physician's order.	The		
PC PC	had a fall. Continued re			1	measurements for the bed	NAME OF THE PARTY.	1	
	November 5, 2011, thr	rough February 6, 2012	, the			Market Commence (
10		ended in the resident's	2	1	were obtained by the Main			
	room, in the wheel cha experienced a total of t			1	Director on 2/6/12 using a s			
	experienced a total of i	ive ialis.		1	tape. The Staffing Coordinate			
10		of the Nurse's Event No	7.77.70	J	a narrative note in the nurse	es notes		
		011, and January 13, 2		1	on 2/6/12 describing the	resident		
		was left unattended in thresident fell on both date		1	with limited functional statu	Section 1		
	Diffing Room and the n	esident leli on both dati	es.	2	the side rails as a restra	•		
		of the comprehensive C	Care					
	Plan as reviewed on De	ecember 22, 2011.		1	Physical Restraint Assessme	ent was		

Division of Health Care Facilities

STATE FORM

PRINTED: 02/28/2012 FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A BUILDING B. WING TN6201 02/21/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD EAST TENNESSEE HEALTH CARE MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) N 424 Continued From page 7 N 424 N 424 1200-8-6-.04(15) cont... revealed "...confusion alteration in thought updated on 2/6/12 by the Staffing process...at risk for falls...bed rails up to define Coordinator for the use of side rails. edge of bed and for mobility...low bed...bed alarm...monitor alarm...do not leave resident Side Rail Assessment unattended while up in chair...resident out of bed Informed Consent was signed by the on awakening...at risk for bleeding secondary to anticoagulation therapy..." family on 2/13/12. On 2/20/12 the MDS Coordinator completed an Medical record review of the January 2012. Physician's Recapitulation Orders revealed "...low Evaluation for use of Side Rails with bed with mats..." a reduction in side rails from full Medical record review of the February 2012. (anti-entrapment) to ½ rails, the Physician's Recapitulation Orders revealed "...low physician was notified and order was bed..." ½ rails. obtained for The Observation on February 6, 2012, at 5:28 p.m., in measurements for the bed zones the resident's room, revealed full side rails on the bed and the bed rail on the left side of bed in the were obtained by the Maintenance up position. Director on 2/20/12. *On 2/23/12 the resident was evaluated again for side Observation on February 13, 2012, at 7:42 a.m., revealed the resident lying on the bed with the clip rail reduction by the Staffing alarm attached to the pillow case. Coordinator, the resident's side rails Interview with the DON on February 13, 2012, at was eliminated and the resident was 7:42 a.m., confirmed the clip alarm was attached placed on a low bed with mats. The to the pillow case and if the resident attempted to exit the bed the clip alarm would not alarm. The Physical Restraint Assessment was DON states, "I'm just going to D/C (discontinue) completed on 2/28/12 by the Staffing it." Coordinator for the elimination of Observation with the DON on February 14, 2012. side rails and the use of a low bed

at 1:53 p.m., revealed the resident lying on the

bed, the bed was not in the lowest position, and the clip alarm was underneath the pillow and not

Interview with the resident's Medical Doctor (MD) on February 14, 2012, at 2:40 p.m., in the Nurse's

attached to the resident.

with

mats

audited

physician's order.

after

by

receiving

the

The care plan

Nursing

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING TN6201 02/21/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD EAST TENNESSEE HEALTH CARE MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 424 Continued From page 8 N 424 Station, revealed the resident "100 percent N 424 1200-8-6-.04(15) cont... absolute risk for bleeding, and head injuries with bleed, due to multiple falls and on anticoagulation Administration Staff to ensure that therapy." Further interview confirmed the MD the plan of care had been updated to was unsure how many falls the resident had experienced, was unaware the facility was using reflect the resident's current status full side rails daily as a restraint, and stated "I do on 2/29/12. not agree with side rails at all times, and feel the facility should have had the resident in a low bed (d) Resident # 57 A telephone order to keep the risk factors down." was received from the resident's Interview with the DON on February 14, 2012, at physician for the use of ½ side rails 12:53 p.m., in the small dining room, confirmed the resident was admitted with risk for falls, had on 2/10/12. The resident was experienced fourteen falls from September 25, assessed on 2/20/12 using the 2011 through February 7, 2012, interventions were put in place not to leave the resident Evaluation for use of Side Rails unattended in room/dining room, clip alarm while indicating the use of ½ side rails by in bed/chair check for placement and function every shift, get out of bed when awakes, and lay the Staffing Coordinator. A Predown for rest periods. Continued interview Restraint Assessment was completed confirmed the facility used full side rails daily to on 2/21/12 by the Director of prevent the resident from transferring unassisted, the resident exited the bed with the full side rails in the up position four times, and the resident was Nursing that indicated side rails are placed back in the bed with full side rails in the up used as a restraint. On 2/24/12 position until February 6, 2012, when the full side rails were removed from the resident's bed. another Evaluation for the use of Further interview confirmed the resident was left Side Rail was completed by the unattended in a bedside chair and wheel chair six Staffing Coordinator indicating the times and the clip alarm failed to sound four times. Continued interview confirmed there was elimination of ½ side rails (no side no documentation the clip alarm was checked for rails are in place at this time). As of function and placement every shift. 2/24/12 the resident's current Observation with the DON on February 14, 2012, interventions include: the locking of at 1:53 p.m., in the resident's room, revealed the resident lying on the bed, the bed not in the wheel chair prior to transfer, offer lowest position, and the clip alarm underneath the rest periods, assist to the bathroom pillow not attached to the resident.

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDII		(X3) DATE SURVEY COMPLETED -	
		TN6201		B. WING_		02/2	1/2012
FAST TENNESSEE HEALTH CARE 465 ISBILI			STREET ADDR 465 ISBILL MADISONVI	RD	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETE DATE
	Resident #18 was adm 15, 2009, with diagnost Dementia, Affective Polypertension. Review of the Resider August 20, 2011 and Morevealed the resident in assistance with all ADD required the use of a more when in a WC (wheeld awareness, and no sididentified. Medical record review	nitted to the facility on a sis including Osteoporo sychosis, Depression and Assessments dated November 14, 2011, required extensive Ls (Activity of Daily Livition-self release seatbethair) due to poor safety derail assessment had be considered in the resident's care in person assist non setup in wheelchair due to Make sure bedrails are in bed to assist with distinct a continued and the bed elevative degrees. Continued the head of the bed, leaving in of the siderail and top it side. Continued the Maintenance Director of the mattress at six and the head of the bed elevative degrees. It is in the bed elevative degrees at six and the head of the bed elevative degrees at six and the head of the bed elevative degrees. It is in the head of the bed elevative degrees at six and the head of the bed elevative degrees. Industry and FDA (For Industr	ing), It y been blan n elf b ated d but a p of	N 424	during rounds and as needed lowest position, a chair sent. The care plan was audited Nursing Administration in the current status on 2/29/12 resident's care plan was reviet the Director of Nursing on and evaluated for fall prestrategies and deemed intervention for constant supduring toileting was inapper After review of current intervention for constant incident (with intervention leave unattended) it was detented that the intervention implemented before a full rocanalysis was conducted intervention was removed.	d, bed in sor pad. by the staff to had been esident's. The ewed by a 3/7/12 evention of the ervision ropriate. Eventions Nursing of the not to ermined was of cause (the	
	and Drug Administration 2006, revealed "Hosp		J,		P		0.

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WNG_ TN6201 02/21/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD EAST TENNESSEE HEALTH CARE MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) N 424 Continued From page 10 N 424 N 424 1200-8-6-.04(15) cont... Dimensional and Assessment Guidance to 2/24/12 interventions above). The Reduce Entrapment...evaluating the dimensional limits of the gaps in hospital beds is one resident remains on the FROG component of an overall assessment and program, participates in restorative mitigation strategy...most vulnerable to entrapment are elderly patients... especially those with ambulation "walk to dine who are frail, confused...incontinence, pain or program", further monitoring and who get out of bed and walk unsafely without interventions will continue to prevent assistance...one component of a bed safety program includes a comprehensive plan for falls. patient assessment...FDA recommends ...a risk benefit analysis to reduce entrapment...FDA (e) Resident #94 The facility staff using a head breadth dimension 4 3/4 inches as provides supervision through routine the basis for its dimensional rounds (minimum of every 2 hours), recommendations...FDA recommends space be small enough to prevent nack entrapment...head during care delivery, activities, and entrapment under the rail less than 4 3/4 meals. The chair sensor pad was inches...in some positions the potential for entrapment exist when the deck is articulated... discontinued on 3/5/12 by the movement of the bed deck is known as Director of Nursing after reviewing articulation...we recommend that patient assessment procedures be used to assess the current interventions. After placing risk of entrapment when clinical care is provided the resident in the correct wheel in an articulated position...FDA have defined zones...could potentially become chair with anti-lock brakes on 2/6/12 trapped...Zone...2(head entrapment under the the resident was identified not to be rail)...accounting for 80% of entrapment events at risk for falls of a similar incident reported...some rails have high and low locking position...requires testing at both positions...Zone (wheel chair rolling back). 2 test...if the space becomes larger as the bed resident utilizes the wheel chair to moves find the bed position that creates the largest space...perform the test with the bed in push himself into a standing the position where the space is the position; the anti-lock brakes prevent largest...common mistakes...not articulating the bed enough to create the largest possible gap..." the chair from rolling providing the Interview with the DON on February 15, 2012 at 3:12 p.m., in the small dining room, confirmed, the faciltiy has no formal assessment tool for use of side rails or what type of siderail to put in place,

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WNG TN6201 02/21/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 465 ISBILL RD EAST TENNESSEE HEALTH CARE MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) N 424 Continued From page 11 N 424 N 424 1200-8-6-.04(15) cont... and no policy and procedure/guidelines for side resident with stability. An identifier rail usage. with the resident's name was Resident #60 was readmitted to the facility on attached to the wheel chair on September 26, 2011, with diagnoses including 2/29/12. The resident's care plan Pneumonia with Aspiration, Alzheimer's Disease, Congestive Heart Failure, Weakness, and GERD was reviewed and updated by the (Gastroesophageal Reflux Disease) Director of Nursing on 2/29/12 to Medical record review of the Pre-Restraint reflect the resident's current status. Assessment dated December 11, 2010, revealed After review of current interventions "...disoriented at times...attempts to transfer/ambulate without assistance...restraint is on 3/7/12 by the Director of Nursing not recommended..." and further investigation of the incident (with intervention not to Medical record review revealed no documentation of a pre-restraint assessment after December 11, leave unattended was not identified 2010, and no restraint reduction assessment as an appropriate intervention to Medical record review of the assessment dated prevent falls). The resident remains December 5, 2011, revealed "...required on the FROG program and does not extensive assistance with bed mobility...moderately impaired for decision require constant supervision, further making...feeds self after set up and no restraints monitoring and interventions will in use..." continue to prevent falls. Medical record review of the Care Plan dated December 5, 2011, revealed "...res (resident) requires bedrails so...may assist Resident # 55 was assessed (f) with...repositioning...cannot transfer or ambulate without assist at this time...resident must be using a Pre-Restraint Assessment sitting upright for all meals..." (used due to the use of side rails as restraint) was completed on 2/6/12 Medical record review of a Fall Risk Assessment dated December 7, 2011, revealed "...risk scale by the MDS Coordinator indicating moderate...equipment issues...side rails..." Medical record review of the February 2012 Physician Recapitulation Orders revealed "...restraint orders...side rails up while in bed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SUI COMPLET				
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N 424	Continued From page 12 facilitate bed mobility"		N 424	N 424 1200-8-604(15) co	nt				
	the resident's room, re the bed with bilateral f position, head of bed of forty-five degrees and the mattress and botto. Observation on Februathe resident's room, re the bed with the full side and the head of bed e forty-five degrees, and the mattress and the bottom observation and intervals.	elevated approximately a gap between the top of the side rails. ary 6, 2012, at 4:50 p.m. evealed the resident lying the rails in the up position of the side rails. Are agap between the top of the side rails in the resident of the siderails. Are with the resident of the siderails. Are of the call light, and the conce, I bumped my on the rails, that is when a gap is visible between the top of the siderail and the top of the of the bed elevated to be degrees. Are with the DON and in the resident's room, and in the resident's	of n., in ng on on of		that a restraint (3/4 side rail a chair) was recommended cognition impaired, plimitations, and history of facare plan was audited by the Administration Staff to ensithe plan of care had been up reflect the resident's current on 2/6/12. No further assected the completed due resident expiring on 2/16/12. 2. The Nursing Administration reviewed all residents using a and the resident's individual assessment scores to identify that may be at risk for injumprehensive assessment completed; interventions modified as needed and plate individuals care planed Administration Team development of the Medical on 2/28/12 to include the ution of the Evaluation for the use Rail Assessment.	due to physical alls. The Nursing ure that dated to at status essments to the on Staff ide rails fall risk by those ury. A to was were acced on a metaloped a with the Director ilization			

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WNG TN6201 02/21/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD EAST TENNESSEE HEALTH CARE MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) N 424 N 424 Continued From page 13 N 424 1200-8-6-.04(15) cont... and measured the gap to be seven and one 3.(a)The administrative staff fourth inch. Further interview with the DON in the (Administrator, Director of Nursing, resident's room confirmed the resident is usually up but has been sick today, has been in the bed Maintenance Director and the most of the day, and the resident moves self in Maintenance Asisstant was inbed using the side rails. serviced on 2/7/12, 2/13/12, and/or Interview with the Maintenance Director, on 2/21/12 by the Regional Nurse February 6, 2012, at 6:38 p.m., in the small dining Consultant and/or Regional Director room, confirmed the side rails were identified as needing to be replaced by his "boss" (Regional of Operations on side rail standards, Maintenance Director). Continued interview with assessment prior to and ongoing use the Maintenance Director confirmed the Maintenence Director was aware of a tool that is of restraints/side rails, resident available to measure the gap between the side assessments, revision of care plans, ails and the mattress but the tool was never available to the facility and the Maintenance how to measure side rails and the Director had no documentation of beds in the recommended zone measurements facility being measured by the tool. per FDA Hospital Bed System Interview with LPN #1 in the Nurses Station on Dimensional and Assessment February 14, 2012, at 7:42 a.m., confirmed the Guidance to Reduce Entrapment resident's head of bed is adjusted as far as possible while eating and is left elevated for at dated March 10, 2006, investigation least forty-five minutes to one hour due to (falls), occurrences of aspiration and choking and the resident ate lunch implementation of interventions to in bed on February 6, 2012. reduce the occurrence of incidents, Interview with Restorative Aide #1 on February effectiveness of monitoring 16, 2012, at 8:50 a.m., in the Nurse's Station, confirmed the CNA lowers side rails, the resident interventions, referring residents for can lift up from the lying position, put feet on floor, therapist by for assessment can hold to the wheel chair and attempts to self-transfer, self transfers from wheel chair to interventions, job appropriate bed side chair, and if the rail on the bed and is in responsibilities, abuse protocol (list the down position can self-transfer chair to bed. inclusive: investigation, not all Interview with the DON on February 14, 2012, at reporting, screening of employees, 8:05 a.m., in the Nurse's Station, confirmed the resident is capable of exiting the bed, and had not employee training).

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dated January 31, 2012, revealed "...found resident lying in floor...alarm not sounding..."

Completion Date: 3/5/12

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with ambulation.

the resident required extensive assistance of two for transfers, and limited assist of two persons

Medical record review Care Plan dated December 5, 2011, revealed "...At risk for falls due to gait disturbance related to weakness and prior falls at home. Resident needs limited to extensive assist with transfers, assistance with

walking and toileting at this time..."

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alarm was applied.

		(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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N 424	Continued From page	17		N 424			
	Telephone interview of 10:50 a.m., with LPN is resident fell on December was left unattended of of the resident's fall, a counseled related to left unattended. Medical record review dated February 3, 20:"Nurse heard pt (pat observed pt on the floor	on February 13, 2012, a #2 confirmed when the her 18, 2011, the resion in the trash can at the ti- ind the CNA had been eaving the resident of a Nurses's Event No. 12, at 7:00 p.m., reveal tient) screaming 'help' a or, fell on buttocks, no	dent me ote ed and				
	move all extremities w Interview on February with the DON, outside	as able to voice needs a without difficulty" 16, 2012, at 10:20 a.m the DON's office confirmation were a rot applied to a	., med		a a		
	resident's wheelchair a fall on February 3, 201 revealed it was unknow using the correct wheel Observation and intervat 8:45 a.m., with Regi	at the time of the reside 2. Continued interview wn if the resident had be chair at the time of the riew on February 13, 20	ent's v eeen e fall. 012,	2			
	resident's room with ar	nti-roll back brakes app confirmed the chair ala	lied				
	9, 2008 with diagnoses	nitted to the facility on J s including Brain Syndro sease, Hypertension, a	ome				
		of the fall risk assessm 011, revealed the resid or falls.	P111120000000				=
	Medical record review	of a Nurse's Event Note	е		9		

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patella (and) tibia..."

Medical record review of a Nurse's Note dated January 24, 2012, revealed "...Resident returned to facility via ambulance/stretcher from (named hospital)...knee immobilizer...Fx (fractured) (left)

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMB		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED	
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N 424	Continued From page 19			N 424	N 601 1200-8-606(1)(a)		
\$0 *)	Interview on February 13, 2012, at 9:10 a.m., in the small dining room, with PTA #1 (witness to the fall) confirmed PTA #1 had observed the resident to stand from the w/c in the resident's room and fall.				Basic Services Requirement:	*	
	Interview on February 13, 2012, at 9:15 a.m., with the DON, in the small dining room, confirmed the intervention to keep the resident in the hall in sight of staff when up in the wheelchair had not been followed on the January 23, and January 24, 2012, falls, resulting in a fractured patella and tibia.			The nursing home must ensure there is an effective, facily performance improvement to evaluate resident caperformance of the organizat	ity-wide program re and		
N 601				N 601	Corrective Action Plan:		*
	 (1) Performance Improvement. (a) The nursing home must ensure that there is an effective, facility-wide performance improvement program to evaluate resident care and performance of the organization. 			1. A special session of Committee was held on 2/2 the Administrator. *The coreviewed the results of the survey as expressed during the survey as expressed during the survey as it with the core survey as it will be core survey as a survey as it will be core survey as a survey as it will be core survey as it will be core survey as a survey as it will be core survey as it will be core survey as a survey as it will be core survey as a sur	mmittee annual ing the		
	facility policy review ar failed to ensure the Qu developed and implem resident safety related likely entrapment and (#41, #18, #60) of fort The facility's failure to plans to address residuse of full side rails, lik likely to cause serious The facility's failure pla	ord review, observation of interview, the facility uality Assurance Commented plans to address to the use of full side realists for three residents review develop and implement safety related to the telly entrapment and fall harm, injury, or death.	nittee s ails, wed. t s ls is		survey exit with the review immediate specifics implementation of the procorrection to remove the implementation. A Side Rail Polideveloped by the QA Committhe Medical Director implementation on 2/28/12 assessment of all residents use of side rails, the review MDS's and Care Plans to	and plan of mediate decy was ttee and with for the for the riew of	

FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WNG TN6201 02/21/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 465 ISBILL RD EAST TENNESSEE HEALTH CARE MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) N 601 N 601 Continued From page 20 current interventions and accuracy; the monitoring by the Administrative The findings included: staff to ensure systems are followed and revised as needed; and to ensure Interview with the Nursing Home Administrator (NHA) and the Regional Director of Operations on staff training is provided as needed February 21, 2012, at 9:15 a.m., in the NHA for processes/systems implemented. office, confirmed falls had been an ongoing Quality Assurance Program. Further interview The QA Committee will review audit with the NHA and Regional Director of Operations results related to the annual survey related to side rails as a restraint, and side rail (list not all inclusive: restraints, side entrapment confirmed the Quality Assurance (QA) Committee had not utilized data from rail side rail assessment, Nurse's Event Notes or information obtained at a Pre-Restraint seminar the NHA had attended in October, 2011 measurements. Physical Restraint in an effort to identify potential areas of Assessment. improvement or implemented a plan to address Assessment, MDS's, Care Plans) areas of concern. discussing and modifying systems as N 615 needed to maintain compliance. N 615 1200-8-6-.06(2)(d)3. Basic Services (2) Physician Services. 2. All residents have the potential to be affected. (d) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall: 3. The OA Committee received in-3. Review reports of all accidents or unusual service training by the Administrator incidents occurring on the premises, identifying and the Regional Nurse Consultant hazards to health and safety and recommending on 2/21/12, 2/22/12, and 2/23/12. corrective action to the administrator; The in-service covered but was not limited to: facility QA Policies and Procedures; Daily QA morning This Rule is not met as evidenced by: meetings; Monthly QA (Leadership Based on medical record review, facility policy review, observation and interview the Medical team, Customer Service, Patient Care Director failed to provide oversight and participate and Service); and Quarterly QA

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in the development of policies and procedures to ensure resident safety and ensure that residents

Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WNG TN6201 02/21/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 465 ISBILL RD EAST TENNESSEE HEALTH CARE MADISONVILLE, TN 37354 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) (goal setting, brainstorming, root N 601 N 601 Continued From page 20 analysis, etc.) The cause Committee will address concerns The findings included: identified during the above meetings Interview with the Nursing Home Administrator as needed, implementing guidelines, (NHA) and the Regional Director of Operations on February 21, 2012, at 9:15 a.m., in the NHA modifications with the assistance of office, confirmed falls had been an ongoing the Medical Director to resolve Quality Assurance Program. Further interview with the NHA and Regional Director of Operations reduce or eliminate concerns related to side rails as a restraint, and side rail The team will review identified. entrapment confirmed the Quality Assurance (QA) Committee had not utilized data from alerts from agencies such as, but not Nurse's Event Notes or information obtained at a limited to: CMS, THCA, and Qseminar the NHA had attended in October, 2011 in an effort to identify potential areas of Source to ensure appropriate improvement or implemented a plan to address measures are taken to obtain the areas of concern. associated with agency goals N 615 N 615 1200-8-6-.06(2)(d)3. Basic Services recommendations. Information discussed in the QA Committee will (2) Physician Services. disbursed to appropriate be (d) The Medical Director shall be responsible for department personnel to improve the medical care in the nursing home. The patient care and services by a QA Medical Director shall: representative through training and Review reports of all accidents or unusual educational sessions. incidents occurring on the premises, identifying hazards to health and safety and recommending corrective action to the administrator; This Rule is not met as evidenced by: Based on medical record review, facility policy review, observation and interview the Medical Director failed to provide oversight and participate in the development of policies and procedures to ensure resident safety and ensure that residents

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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N 601	The findings included: Interview with the Nursing Home Administrator (NHA) and the Regional Director of Operations on February 21, 2012, at 9:15 a.m., in the NHA office, confirmed falls had been an ongoing Quality Assurance Program. Further interview with the NHA and Regional Director of Operations related to side rails as a restraint, and side rail entrapment confirmed the Quality Assurance (QA) Committee had not utilized data from Nurse's Event Notes or information obtained at a seminar the NHA had attended in October, 2011 in an effort to identify potential areas of improvement or implemented a plan to address areas of concern.		N 601	4. The Administrator or Director of Nursing will review facility audits in morning QA meetings (Monday-Friday) and in the quarterly QA meeting to review areas that have improved and/or may need revisions. Action plans will be developed when a practice is determined to be deficient; the committee will monitor until compliance is met. For Clarification Purposes: The QA Committee consists of Medical Director, Administrator, Director of			
			al ng ling y I pate s to		Nursing, Assistant Director Nursing, MDS Coordi Bookkeeper, Food Supervisor, Social Maintenance Director	ctor of inator(s), Service Worker, and/or Activities (list not Nurses,	

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WNG_ TN6201 02/21/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 465 ISBILL RD EAST TENNESSEE HEALTH CARE MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) N 601 Continued From page 20 N 601 The findings included: Interview with the Nursing Home Administrator (NHA) and the Regional Director of Operations on February 21, 2012, at 9:15 a.m., in the NHA office, confirmed falls had been an ongoing Quality Assurance Program. Further interview with the NHA and Regional Director of Operations related to side rails as a restraint, and side rail entrapment confirmed the Quality Assurance (QA) Committee had not utilized data from Nurse's Event Notes or information obtained at a seminar the NHA had attended in October, 2011 in an effort to identify potential areas of improvement or implemented a plan to address N 615 1200-8-6-.06(2) (d) 3 areas of concern. **Basic Services-Physician Services** N 615 N 615 1200-8-6-.06(2)(d)3. Basic Services Requirement: (2) Physician Services. The Medical Director shall be (d) The Medical Director shall be responsible for responsible for the medical care in the medical care in the nursing home. The Medical Director shall: the nursing home. The Medical Director shall: Review reports of all 3. Review reports of all accidents or unusual incidents occurring on the premises, identifying unusual incidents or accidents hazards to health and safety and recommending premises, the on occurring corrective action to the administrator; identifying hazards to health and safety and recommending corrective action to the administrator. This Rule is not met as evidenced by: Based on medical record review, facility policy review, observation and interview the Medical Director failed to provide oversight and participate in the development of policies and procedures to

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ensure resident safety and ensure that residents

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N 615	Continued From page with restraints were properly and restraint reduction implemented where as the facility to develop procedures related to residents #18, #41, and which was detrimental welfare. The findings included: Interview with the Med Fabruary 13, 2012 at dining room, revealed by the facility related to unaware of the types of facility; and was unaway with the siderails, or of the MD stated reviewee either on rounds or in 0 but was unaware of fall siderails or entrapment. The MD further stated bed with siderails show with fall mats and sider discontinued."	roperly assessed, mana nor elimination was appropriate. Is failure to collaborate wand implement policies resident safety placed and #60 in an environme of the MD was never called to siderail issues; was of siderails used in the are of potential entraper falls due to siderail used all falls in the facility QA (Quality Assurance) lls with injuries due to the issues until last week. "residents who exit the injuries due to the placed in low bed rails should be	aged, with and and ent ent ed nent e.),	N 615	N 615 1200-8-606(2) (Basic Services-Physician Corrective Action Plan: 1. The facility's Medica was made aware Administrator on 2/8/12 facility had received jeopardy level deficiencie F 490 for the manner in facility has been administ Quality Assurance Commute with the Medical Director to review deficiencies si the facility's recent annuincluding those affecting #41, 18, and 60. The Administrator on Hospital Bed System Diand Assessment Guidance Entrapment dated March 16.	al Director by the 2 that the immediate is including which the rated. The mittee met on 2/23/12 ted during hal survey, g resident ministrator The FDA imensional to Reduce 0, 2006.
6	some of the Quality Assurance Committee Meetings; is not involved in oversight and implementation of facility policies and procedures related to resident safety; and there was no system in place to identify and respond to these safety risks.				be affected. The Adm Team developed a Side R with the involvement of th Director and implemented	ninistration Lail Policy ne Medical
N1208	1200-8-612(1)(h) Res	ident Rights		N1208		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/O		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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N 615	Continued From page	21		N 615	on 2/28/12 to include the ut	ilization		
8	with restraints were properly assessed, managed, and restraint reduction or elimination was implemented where appropriate. The Medical Director's failure to collaborate with the facility to develop and implement policies and procedures related to resident safety placed residents #18, #41, and #60 in an environment which was detrimental to their health, safety and welfare.			of the Evaluation for the use Rail Assessment. 3. The Administrator revie functions and responsibiliti Medical Director on 2/23/	wed the les with 12. The			
			and		Administrator and/or Dire Nursing will notify the Director as needed regardin	Medical		
	The findings included:	e findings included:			that requires the revision			
	Interview with the Medical Director (MD) on February 16, 2012, at 12:00 p.m., in the small dining room, revealed the MD was never called by the facility related to siderail issues; was unaware of the types of siderails used in the facility; and was unaware of potential entrapment with the siderails, or of falls due to siderail use. The MD stated reviewed all falls in the facility either on rounds or in QA (Quality Assurance), but was unaware of falls with injuries due to siderails or entrapment issues until last week. The MD further stated "residents who exit the bed with siderails should be placed in low beds with fall mats and siderails should be discontinued."			development of policie procedures to meet the mare resident and/or staff. 4. The Administrator will refunctions of the Medical through random audits and that the development/revisipolicies or systems is compute quarterly QA meeting needed. Completion Da	view the Director I ensure sion of bleted in and as			
	some of the Quality A Meetings; is not involv implementation of faci related to resident saf		dures		Completion Da			
N1208	1200-8-612(1)(h) Re	sident Rights		N1208				

STATE FORM

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WNG TN6201 02/21/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD EAST TENNESSEE HEALTH CARE MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) N1208 Continued From page 22 N1208 (1) The nursing home shall establish and implement written policies and procedures setting forth the rights of residents for the protection and preservation of dignity, individuality and, to the extent medically feasible, independence. Residents and their families or other representatives shall be fully informed and documentation shall be maintained in the resident's file of the following rights: (h) To be free from chemical and physical restraints; This Rule is not met as evidenced by: pased on Guidance for industry and FDA (Food and Drug Administration March 2006) medical record review, facility policy review, observation, and interview, the facility failed to assess side rails as a restraint, failed to ensure siderails did not pose a risk for entrapment, and failed to reduce or eliminate side rail restraints for six residents (#41, #60, #18, #83, #55, #57) of forty three residents reviewed. The facility's failure to follow a systematic process of assessing for appropriate use of the restraint and failure to reduce or eliminate side railrestraints placed residents #41, #60, and #18 in an environment which was detrimental to their health safety and welfare.. The findings included: Review of the facility restraint policy dated August 2010, revealed,"...A restraint includes, but is not limited to any article, device, or garment that interferes with freedom of movement of the pt (patient) and that cannot be removed by the pt easily...Restraints must be used only after all

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Division	of Health Care Facilitie	es				FORI	M APPROVED	
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN6201		CLIA ER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SU COMPLE		
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N1208	Continued From page	23		N1208	N 1208 1200-8-612(1) (h)			
	between restraint use ptAll restraints must	failedthere must be a & (and) how it benefits have: physicians order			Resident Rights			
	restraint should be use	acluding the type of restraint, when & where the estraint should be used, the medical necessity of the restraint and restraint reduction attempts			Requirement:			
	documented on the ca	re plan.			The nursing home shall esta	olish and		
	Resident #41 was adm	nitted to the facility on			implement written polic	ies and		
	September 23, 2011, and readmitted to the facility on October 24, 2011, with diagnoses including Alzheimer's Disease, Deep Vein Thrombosis and Hypertension.			procedures setting forth the rights of				
					residents for the protect	ion and		
1					preservation of dignity, indi			
	17				and, to the extent medically			
,		of a Fall Risk Assessm 2011, revealed "mode		independence. Residents and their				
i		ide rails" Medical reco					,	
		e-restraint assessment t			families or other representati			
	the use of the side rails for the use of side rails	s and no physician orde	er		be fully informed and docum			
	for the use of side falls	•			shall be maintained in the r			
	Medical record review		a		file of the following -	physical		
	Assessment Document date September 30, 20		r	1	estraints.			
	restraint used in bedd		.	'		**		
	railscurrentlyboth si side rails were not care	ide rails up". The full planned.			Corrective Action Plan:			
	Medical record review of dated September 27, 2 "found resident lying	011, at 6:15 a.m., reve			through the comp	rironment rehensive		
	Medical record review of				assessment of each residen	AND THE SHARE SERVICES		
	dated September 27, 29 up(intervention)pres		ails	İ	the resident's needs and ma	intaining		
	up(intervention)pres	soure release alarm			their optimal physical, me	ental and		
1	*10 * 0 * 0,0 •960 to disciplinate properties (*100 €)				psychosocial well being.			
	Medical record review of							
	dated September 30, 20 8:15 p.m., revealed "f		ed					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBI TN6201	CLIA ER:	(X2) MULTI A. BUILDIN B. WING		(X3) DATE SUR COMPLETE	ED
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	rails were upalarm No new interventions were noted. Medical record review dated September 30, up(intervention)in properly operate bed Medical record review dated October 4, 201 "pt (patient) on his I on to raised bed (brin (times) 3" Medical record review Readmission Assessi 2011, revealed "req of daily livinginconti bladdercombative a decisionsand history Medical record review assessment dated Oc "high risk for fallss Medical record review Assessment dated Oc the resident had no si restraints, and "no res elimination is planned review revealed no pr assessment and no pl side rails.	w of the facility investigated and the side of a Nurse's Event Not a larm" w of a Nurse's Event Not a larm" w of a Nurse's Event Not a larm" w of a Nurse's Event Not a larm, revealed the side of bed holding up) railsabrasion x w of the Nurse's ament dated October 24, quired assist with all activities activities and at timesunable to make any of falls" w of the Fall Risk ctober 24, 2011, revealed side rails" v of a Physical Restraint ctober 24, 2011, revealed igned consent for use of straint reduction or "". Further medical record	rails ation rails to te d diding vities	N1208	(a) Resident #41's plan of reviewed and revised, after a his fall potential risks, his were removed. His care plan the new interventions. (b) Resident # 60 The side were in place during the sur immediately changed to entrapment rails (prior to the surveyors) on 2/6/12 Maintenance Director. The Assessment and Informed Form (one form) was later comby the Staffing Coordin 2/6/12 for the use of side rail reduction from full side raiside rails after receive physician's order for the unrails by the Staffing Coordin (after the exit of the surveyord evening) that were changed the Maintenance Director. Restraint Assessment was contained to the surveyord extends the surveyord evening that were changed the Maintenance Director.	rails that receive were full anti- he exit of the Side Rail Consent completed attor on a see of ½ ordinator rs for the lout per The Pre- completed Staffing	
	dated November 23, 2 "found on the floor b	2011, at 6:00 a.m., revea peside bed resident had railsskin tearabrasio	aled	1	being used as a restraint and a	٥	

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING B. WNG TN6201 02/21/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD EAST TENNESSEE HEALTH CARE MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) N1208 Continued From page 25 N1208 An Evaluation for the use of Side Review of the facility investigation report dated Rails was completed on 2/23/12 by November 23, 2011, completed by the DON the Staffing Coordinator with a revealed "...climbed over the side rails... (intervention)...low bed with mats..." No new reduction of side rails from ½ side interventions for removal of the full side rails were rails to ¼ side rail in combination noted. with a low bed. The bed/side rails Medical record review of the Interdisciplinary Plan were changed by out the of Care reviewed on December 22, 2011, Maintenance Director; measurements revealed "...confusion alteration in thought process...at risk for falls...bed rails up to define were obtained on 2/23/12. The care edge of bed and for mobility...low bed...bed plan was audited by the Nursing alarm...monitor alarm...do not leave resident unattended while up in chair...at risk for bleeding Administration Staff to ensure that secondary to anti coagulation therapy...". the plan of care had been updated to Medical record review of the January 2012. reflect the resident's current status Physician's Recapitulation Orders revealed "...low on 2/26/12. bed with mats...", and no order for side rails. Medical record review of a resident assessment (c) Resident #18 The Staffing dated January 23, 2012, revealed the resident Coordinator wrote a narrative note in had severe cognitive impairment, required extensive assistance with bed mobility, transfers the nurses notes on 2/6/12 describing and ambulation, and full side rail restraints were the resident with limited functional used daily. status using the side rails as a Medical record review of the February 2012. Physical Restraint restraint. A Physician's Recapitulation Orders revealed "...low Assessment was updated on 2/6/12 bed...", and no order for side rails. by the Staffing Coordinator for the Observation on February 6, 2012, at 5:28 p.m., in use of side rails. A Side Rail the resident's room, revealed full side rails on the bed and the bed rail on the left side of bed in the Assessment and Informed Consent up position. Interview with Licensed Practical Nurse (LPN) #1 on February 14, 2012, at 7:50 a.m., at the Nurse's Station, confirmed the resident was in the bed prior to the fall on September 30, 2011; the full

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	September 26, 2011, Pneumonia with Aspir Congestive Heart Fail (Gastroesophageal Romedical record review dated December 5, 20 extensive assistance with makingfeeds self aftuse" Medical record review of Care dated December 10 feeds	idmitted to the facility of with diagnoses includir ration, Alzheimer's Diseure, Weakness, and Gleflux Disease) of a resident assessmult, revealed "require with bed impaired for decision er set upno restraints of the Interdisciplinary per 5, 2011, revealed "realed "realed "resident must be eals" of a Fall Risk Assessmult, revealed "risk scalissues side rails" of the Pre-Restraint pember 11, 2010, revealed "tember 11, 2010, revealed the resident lying in the up levated approximately levated approximately	ent ed ent ed ent elected ent	N1208	2. The Nursing Administrate reviewed all residents ustrails, assessing and cooresident's assessment Residents using side rait restraint were identified a planned accordingly. comprehensive assessment completed; interventions modified as needed and puthe individuals care play Administration Team deverside Rail Policy with involvement of the Medical with implementation on 2/2 include the utilization Evaluation for the use of States Assessment.	sing side ding the correctly. Is as a and care A and was were laced on an. The eloped a th the Director 28/12 to of the	

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING TN6201 02/21/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD EAST TENNESSEE HEALTH CARE MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) N1208 Continued From page 28 N1208 3.(a)The administrative staff (Administrator, Director of Nursing, the mattress and the bottom of the side rails. Maintenance Director and Observation on February 6, 2012, at 4:50 p.m., in Maintenance Asisstant was inthe resident's room, revealed the resident lying on the bed with the full side rails in the up position, serviced on 2/7/12, 2/13/12, and/or the head of bed elevated approximately forty-five 2/21/12 by the Regional Nurse degrees and a gap between the top of the mattress and bottom of the side rails. Consultant and/or Regional Director of Operations on side rail standards, Observation and interview with DON and assessment prior to and ongoing use Maintenance Director in the resident's room, on February 6, 2012, at 5:35 p.m., revealed the of restraints/side rails, resident resident's head of the bed elevated to forty five assessments, revision of care plans, degrees; the Maintenance Director measured the full side rails from the top of the mattress to the how to measure side rails and the bottom of the full side rail in the middle of the bed recommended zone measurements and measured the gap to be seven and one fourth inches. per FDA Hospital Bed System Dimensional and Assessment Review of Guidance for Industry and FDA (Food and Drug Administration) Staff dated March 10, Guidance to Reduce Entrapment 2006, revealed "...Hospital Bed System dated March 10, 2006, investigation Dimensional and Assessment Guidance to Reduce Entrapment...evaluating the dimensional of occurrences limits of the gaps in hospital beds is one implementation of interventions to component of an overall assessment and reduce the occurrence of incidents, mitigation strategy...most vulnerable to entrapment are elderly patients... especially those monitoring effectiveness who are frail, confused...incontinence, pain or interventions, referring residents for who get out of bed and walk unsafely without assistance...one component of a bed safety therapist assessment by for program includes a comprehensive plan for interventions, appropriate job patient assessment...FDA recommends ...a risk benefit analysis to reduce entrapment...FDA responsibilities, abuse protocol (list using a head breadth dimension 4 3/4 inches as not all inclusive: investigation, the basis for its dimensional reporting, screening of employees, recommendations...FDA recommends space be small enough to prevent neck entrapment...head employee training). entrapment under the rail less than 4 3/4 inches...in some positions the potential for

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	movement of the bed articulationwe reco assessment procedurisk of entrapment whin an articulated posizonescould potentitrappedZone2(herail)accounting for reportedsome rails positionrequires test 2 testif the space bed moves find the bed plargest spaceperforthe position where the largestcommon middle bed enough to create Interview with Restor 2012, at 10:07 a.m., confirmed full side rails in the bed, and ware in use for this resident "has always while in bed". Interview with the Droon February 6, 2012 most recent pre-rest completed December the facility had not consider the small dining roo the small dining roo	en the deck is articulated deck is known as mmend that patient res be used to assess the clinical care is provided. FDA have defined ally become addentrapment under the solution of entrapment event have high and low lock sting at both positions recomes larger as the broad to that creates the rm the test with the bedies pace is the stakes not articulating the largest possible garative Aid #2, on Februarin the Nurse's Station, alls are up while the resident. For on February 13, 2012 and the full side rails under the full side rails under the full side rails under 10, 2010, and confirmed training assessment was and only completed any restraint	the ided of the ided of the ided of the ided of the identification	N1208		12, 2/7/12, and if by the ce Director of Nursing led to: the Assessment Evaluation Rails to be use of side Assessment, Assessment and how the expleted), the obtain bed in the FDA is. All staff diministrator, and/or the garding but letion of Side Informed in the use of leted prior to Pre-Restraint		

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WNG TN6201 02/21/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD EAST TENNESSEE HEALTH CARE MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE TAG DEFICIENCY) Assessment (when, on whom, why, N1208 Continued From page 30 N1208 and how the assessment is to be side rails to use; no specific order for type of side rails to be used; the facility is in process of completed), the risk of entrapment changing the side rails to one-half side rails, "only associated with side rail use and how able to order so many at a time due to financial reasons," and the concern with full side rails to obtain bed zone measurements per (used as a restraint) was identified back in the the FDA "best practice" standards on summer 2011. 2/29/12. Interview with the DON on February 14, 2012, at 4. (a) The Director of Nursing or the 8:05 a.m., in the Nurse's Station, confirmed the Assistant Director of Nursing will resident was capable of exiting the bed, and an audits (Mondayconduct daily assessment to determine if use of the side rails Friday) for 90 days through facility was the least restrictive device had not been completed prior to February 6, 2012, after the walking rounds, review of the 24 Maintenance Director measured the seven and hour report, care plans, Nurse Aide one-forth inch gap between the mattress and Communication Sheets, Evaluation bottom of the side rail. for the Use of Side Rails, and Nurse Interview with the resident's Physician at 9:12 Event notes to ensure the appropriate a.m., on February 21, 2012, by telephone, procedures and policies are being confirmed no physician's order had been given followed, then weekly audits times for use of side rails and "was not aware" of the 90 days, then random audits as long facility using side rails for resident #60. as compliance is maintained. If at Resident #18 was admitted to the facility on June any time compliance is not met, 15, 2009, with diagnoses including Osteoporosis, daily audits will resume until Dementia, Affective Psychosis, Depression and Hypertension. compliance is obtained. The audit findings will be reviewed the Review of the resident's assessments dated August 20, 2011, and November 14, 2011, morning Quality Assurance Meeting revealed the resident required extensive (Monday-Friday) and review with assistance with all ADLs (Activities of Daily the Medical Director in the quarterly Living) and required the use of a non-self release QA meeting and as needed. seatbelt when in WC (wheelchair) due to poor safety awareness. No other restraints were Completion Date: 3/5/12 identified on the comprehensive quarterly assessments. Review of the resident's Care Plan dated

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING TN6201 02/21/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD EAST TENNESSEE HEALTH CARE MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) N1208 | Continued From page 31 N1208 February 6, 2012, revealed, "... Transfer in and out of bed using 2 person assist...non self release soft belt when up in wheelchair due to poor safety awareness...Make sure bedrails are up X2 (both sides) when in bed to assist with mobility ... " Medical record review revealed no assessment for siderail use. Continued medical record review of the January 2012 and February 2012 Physician's Recapitulation Orders revealed no order related to side rail use as a restraining device or as a mobility aide. Observation with the Maintenance Director, on February 6, 2012, at 6:55 p.m., revealed the resident in bed, with the head of the bed elevated to approximately forty-five degrees. Continued observation revealed full sideralls bilaterally, but raised only on the left side of the bed, leaving a gap between the bottom of the siderail and mattress on the left side. Continued observation revealed the Maintenance Director measured a gap between the bottom of the siderail and the top of the mattress at six and one-half inches, with the head of the bed elevated revealing potential entrapment risk. Observation on February 13, 2012, at 3:30 p.m. revealed the resident resting in bed with half side rails up bilaterally at the resident's chest position extending to the knee position. Interview with the DON on February 6, 2012, at 6:10 p.m., in the small dining room, confirmed the side rails had not been assessed as a restraint. Resident #83 was re-admitted to the facility on March 16, 2011, with diagnoses including Alzheimer's Disease, Dementia, Osteoarthritis, Osteoporosis, Dysphagia w/ PEG tube

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N1208	Continued From page 32			N1208	***				
	(percutaneous-esoph	ageal-gastrostomy tube	≘).		F)		1997 1 20		
VI (7)		ugust 28, 2011, and caled the resident requi		21					
	extensive assistance of one to two staff members for all activities of daily living. Continued MDS review revealed no restraints were used.						100 S 12		
	March 21, 2011, and 2011, revealed "Re- transfers and mobility	of a Care Plan dated updated November 29, sident relies on staff for and could not prevent. up X 2." Continued car	all self		9				
	October 5, 2011, stati	an added intervention or ing "ensure that side efore leaving the room."	rails						
	the March 21, 2011, of subsequent restraint a	d review revealed no ent on admission or pricare plan for side rails., assessments had been ast restrictive device wa	nor				2		
	side rails in the up po	ation Orders revealed erail) up X (times) 2 (bila sition) for bed mobility. physician's orders reveal to February 9, 2012,			_				
	at 9:07 a.m., February February 9, 2012 at 1	esident on February 6, 2 y 7, 2012, at 8:23 a.m., 0:10 a.m., revealed the lone in the room, with b in the "up" position.	and						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM TN6201			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/21/2012			
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	assure it is the least r maintainingsafety Medical record review December 15, 2011, gentle reminder to ca positioning"	v of the care plan dated revealed, "Bedrails x Il for assist and for v revealed no pre-restra aint reduction assessm	I 2 as aint					

Division of Health Care Facilities STATE FORM

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N1208	Continued From page 34			N1208				
	Observation on February 6, 2012, at 1:50 p.m. revealed the resident lying on the bed with full siderails up bilaterally.							
9	Interview on February 15, 2012, at 10:40 a.m., with the Director of Nursing, in the small dining room confirmed no assessment for the use of the siderails had been completed prior to February 6, 2012. Resident #57 was admitted to the facility on November 11, 2010, with diagnoses including Alzheimer's Disease, Hypertension, and Senile Dementia.							
	Medical record review of the resident's assessment dated January 4, 2012, revealed the resident had severe cognitive impairment, was independent for locomotion on and off unit, was placed in a chair that prevented the resident from rising and bed side rails were used daily as restraints.		as vas					
	of Care dated January rails up times two per	resident on commode	side					
	Medical record review Physician Recapitulat order for side rails.	of the January 2012, ion Orders revealed no						
		of the February 2012, ion Orders revealed no						
	Medical record review revealed no documentation							

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PRINTED: 02/28/2012 FORM APPROVED Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WNG TN6201 02/21/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 465 ISBILL RD EAST TENNESSEE HEALTH CARE MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) N1208 N1208 Continued From page 35 of a pre-restraint assessment or a restraint reduction assessment for the use of the chair and the side rails. Observation on February 6, 2012, at 4:02 p.m., in the resident's room, revealed the resident lying on the bed with one-half side rails in the up position on both sides of the bed. Interview with LPN #7 on February 7, 2012, at 11:17 a.m., in the break room, confirmed the resident has one-half side rails used daily, and the resident is capable of exiting the bed without assistance. Interview with the DON on February 8, 2012, at 8:42 a.m., in the Nurse's Station, confirmed racility had not completed a pre-restraint assessment or restraint reduction assessment. Interview with the Director of Nursing (DON) on February 6, 2012, at 6:12 p.m., in the small dining room, confirmed the DON was unaware of any residents attempting to exit the beds over the side rails; the facility performs side rail assessments on admission only; the facility has no formal assessment for use of side rails or what type to put in place; the facility has no policy and procedure/guidelines for side rails; and if a resident attempted to exit a bed with side rails in use they would be placed in a low bed. Further interview confirmed the DON attended a meeting this past year and was informed the facility needed to start reducing side rail use.

In summary, the facility failed to provide a system to ensure residents were assessed prior to the use of side rails to determine medical necessity, and if the side rails were the appropriate least restrictive device to maintain the resident's safety.

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Division of Health Care Facilities STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WNG_ TN6201 02/21/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 465 ISBILL RD EAST TENNESSEE HEALTH CARE MADISONVILLE, TN 37354 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY)

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N 615	STREET ADDRI 465 ISBILL E MADISONVII SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 21 with restraints were properly assessed, managed, and restraint reduction or elimination was implemented where appropriate. The Medical Director's failure to collaborate with the facility to develop and implement policies and procedures related to resident safety placed residents #18, #41, and #60 in an environment which was detrimental to their health, safety and welfare. The findings included: Interview with the Medical Director (MD) on February 16, 2012, at 12:00 p.m., in the small dining room, revealed the MD was never called by the facility related to siderail issues; was unaware of the types of siderails used in the facility; and was unaware of potential entrapment with the siderails, or of falls due to siderail use. The MD stated reviewed all falls in the facility either on rounds or in QA (Quality Assurance), but was unaware of falls with injuries due to siderails or entrapment issues until last week. The MD further stated "residents who exit the bed with siderails should be placed in low beds with fall mats and siderails should be discontinued." Continued interview revealed the MD attended some of the Quality Assurance Committee Meetings; is not involved in oversight and implementation of facility policies and procedures related to resident safety; and there was no system in place to identify and respond to these		N 615	on 2/28/12 to include the ut of the Evaluation for the use Rail Assessment. 3. The Administrator review functions and responsibilities Medical Director on 2/23/Administrator and/or Director as needed regarding that requires the revision development of policies procedures to meet the marked resident and/or staff. 4. The Administrator will resident and/or staff. 4. The Administrator will resident and/or staff. 4. The Administrator will resident and/or staff. Completion Dameded. Completion Dameded.	e utilization use of Side eviewed the folities with 23/12. The Director of the Medical rding issues sion and/or ticies and the needs of I review the the tal Director and ensure revision of the ompleted in the ing and as			
N1208	safety risks.			N1208				

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Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 02/21/2012 TN6201 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 465 ISBILL RD EAST TENNESSEE HEALTH CARE MADISONVILLE, TN 37354 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) on 2/28/12 to include the utilization N 615 N 615 Continued From page 21 of the Evaluation for the use of Side with restraints were properly assessed, managed, and restraint reduction or elimination was Rail Assessment. implemented where appropriate. 3. The Administrator reviewed the The Medical Director's failure to collaborate with the facility to develop and implement policies and functions and responsibilities with procedures related to resident safety placed Medical Director on 2/23/12. The residents #18, #41, and #60 in an environment Administrator and/or Director of which was detrimental to their health, safety and welfare. Nursing will notify the Medical Director as needed regarding issues The findings included: that requires the revision and/or development of policies and Interview with the Medical Director (MD) on February 16, 2012, at 12:00 p.m., in the small procedures to meet the needs of dining room, revealed the MD was never called resident and/or staff. by the facility related to siderail issues; was unaware of the types of siderails used in the facility; and was unaware of potential entrapment 4. The Administrator will review the with the siderails, or of falls due to siderail use. functions of the Medical Director The MD stated reviewed all falls in the facility through random audits and ensure either on rounds or in QA (Quality Assurance), but was unaware of falls with injuries due to that the development/revision of siderails or entrapment issues until last week. policies or systems is completed in The MD further stated "...residents who exit the bed with siderails should be placed in low beds the quarterly QA meeting and as with fall mats and siderails should be needed. discontinued." Completion Date: 3/5/12 Continued interview revealed the MD attended some of the Quality Assurance Committee Meetings; is not involved in oversight and implementation of facility policies and procedures related to resident safety; and there was no system in place to identify and respond to these safety risks. N1208

N1208 1200-8-6-.12(1)(h) Resident Rights